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February 21, 2007

AGENDA ITEM 10

TO: MEMBERS OF THE HEALTH BENEFITS COMMITTEE

I. SUBJECT: First Reading - Potential 2008 Health Program Benefit Design

II. PROGRAM: Health Benefits

III. RECOMMENDATION: Information Only – First Reading

IV. INTRODUCTION:

At the June 20, 2006, Health Benefits Committee (HBC) meeting, staff proposed a set of benefit design options for CalPERS basic plans to help moderate premium increases and provide our members with incentives to obtain care in the most cost-effective clinically beneficial setting. Committee members expressed concern about the impact that benefit design changes may have on members, deferring consideration of changes to 2008 rate negotiations. This agenda item introduces a set of changes for the Committee's consideration.

V. BACKGROUND:

CalPERS last approved changes to its benefit design in 2002. Since that time, premiums for the Basic HMO plans have increased by 101 percent, Basic PPO plans by 78 percent, Medicare HMO plans by 85 percent and Medicare PPO plans by 16 percent.

In 2006, HBC considered the following benefit design changes:

2006 Proposed Benefit Changes

A. For Blue Shield, Kaiser and Western Health Advantage (WHA) basic plans:
1. Increase office visit co-payments from $10 to $15
2. Increase emergency room co-payments from $50 to $75 (waived if admitted as an inpatient or for observation as an outpatient)
3. Introduce co-payment of $100 per hospital inpatient admission

4. Introduce ambulatory surgery co-payment of $25

B. For PERS Choice basic plan:
1. Introduce co-payment of $100 per hospital inpatient admission

C. For PERS Choice and PERSCare basic plans:
1. Increase emergency room co-payments from $50 to $75 (waived if admitted as an inpatient or for observation as an outpatient)

Members of the HBC expressed concern about the impact increased cost sharing might have on our members and that these types of changes might create barriers to services resulting in members postponing needed care. The HBC is especially concerned about the impact of such changes on low income members and those with chronic conditions.

To address the Board's concerns, CalPERS staff engaged Milliman, Inc. to develop a benefit design proposal given the following objectives:

- Encourage members to seek care in the most appropriate and cost-effective setting: the proposed benefit design will encourage members to make high quality, low cost provider choices when viable alternatives to lower cost delivery systems exist
- Reduce overall long-term premium increases: the proposed benefit design will balance short-term premium savings against potential changes in patient behavior that may cause patients to forgo needed care, resulting in decreased quality of life for our members and long-term premium increases
- Provide incentives for members to make healthy lifestyle choices: the proposed benefit design will encourage our members to adopt healthy behaviors improving their overall health, while reducing their health care premiums
- Maintain our risk pool: the proposed benefit design will balance benefits and premiums to provide value to public agencies, encouraging our contracting agencies to continue CalPERS health care coverage, and motivating new public agencies to join our program
- Ensure competitiveness in health benefits marketplace: the proposed benefit design will be competitive with other large employer offerings and consistent within plan types. This will allow CalPERS employers to continue to offer health care benefits to attract high quality employees and ensure that our HMO plans compete for CalPERS membership based on premium
- Maintain consistency with applicable state and federal laws: the proposed benefit design must comply with all state and federal laws

The remainder of this agenda item analyzes how well the proposed benefit design for our HMO, and PPO basic plans meets the above objectives. Staff is working with Milliman to analyze our Medicare plan benefit designs and may provide the HBC with a proposal for change in the future. Staff will work with our plans during rate negotiations to ensure they can implement our proposal and to

obtain specific premium impacts for the proposed HMO basic plan benefit design changes. In addition, staff will continue to analyze the benefit design to address Committee and constituent concerns in future agenda items.

VI. ANALYSIS:

Proposed HMO Basic Benefit Design

After extensive analysis and collaborative discussions with staff, Milliman proposed the following benefit design changes for our HMO basic plans:

1. Office visit co-payments from $10 to $15 and waive co-payments for preventive care (periodic health exams, obstetrics, well baby visits, allergy testing and treatment, immunizations, hearing evaluations, and pre/post-natal care)
2. Hospital inpatient co-payments from $0 to $100 per day with an annual maximum of $300, standardizing the ambulatory surgery co-payment at the proposed office visit co-payment of $15 (Kaiser currently charges a $10 office visit co-payment for ambulatory surgery, while Blue Shield and WHA currently charge $0)
3. Pharmacy co-payments from $5 for generic, $15 for brand, and $45 for non-formulary at retail and $10/25/75 at mail order, to $5/20/45 at retail and $10/40/90 for mail order (Kaiser would change from $5/15 at retail and mail, to $5/20)
4. Emergency room co-payments from $50 to $75 (waived if admitted), while standardizing the urgent care co-payment across all plans to the proposed office visit co-payment of $15 (currently urgent care co-payments are $10 for Kaiser, $25 for Blue Shield and $20 for WHA)
5. Out-of-pocket maximums to a standardized $1,500 for individuals and $3,000 for families, excluding pharmacy (Blue Shield has no out-of-pocket maximum. Kaiser and WHA have a $1,500/$3,000 out-of-pocket maximum.)

All of the changes in the proposed benefit design are consistent with applicable state and federal laws. In addition, they either generate long-term premium savings, result in co-payments that are at or below the standard of what other large employers offer, or both. These two factors ensure that the proposed benefit design:

- Is competitive with other large employer offerings
- Balances benefits and premiums to provide value to public agencies

The following table displays the industry standard co-payment for each proposed HMO basic plan change:

Change		Industry Standard
Office Visit:	$15, $0 preventive care	$15
Hospital Inpatient:	$100 per day, $300 annual cap	$250 per admit
Pharmacy:	$5/20/45 retail, $10/40/90 mail order	$10/20/39
Emergency Room:	$75	$50 to $100
Out-of-pocket Maximums:	$1,500/$3,000	$1,500/$3,000

Source: Industry Standard - Milliman estimate of median co-payment for employers with 100 or more employees based on "2006 California Survey of Employers." Milliman estimate of emergency room median based on analysis of large health plan documents.

The remainder of our analysis is based on Milliman's literature review. Literature on patient impact for many of our specific proposed changes is sparse. Staff proposes that any change in benefit design be followed by a thorough investigation of the impact on CalPERS' members. Staff will provide CalPERS utilization data at the February HBC meeting.

Change to office visit co-payments: This change decreases the office visit co-payment for preventive care to $0, and sets all other office visit co-payments at $15.

By decreasing preventive care office visit co-payments to $0, our benefit design provides members with a financial incentive to seek preventive care including screening for chronic illnesses. Early intervention is key to ensuring members' chronic conditions do not escalate to more costly states. Members may also get more frequent lifestyle counseling from physicians if they seek preventive care. Milliman notes that this approach is becoming more popular among large employers, including the federal government.

In addition to changing the preventive care office visit co-payment, Milliman proposes changing the office visit co-payment to $15. Based on Milliman's literature review, small incremental changes in office visit co-payments do not cause patients to forgo needed care resulting in decreased quality of life. Since CalPERS last approved co-payment changes in 2002, premiums for HMO Basic plans have increased by at least $192. The proposed office visit co-payment increase of $5 is far less than the health premium increase CalPERS experienced since the last change to co-payments.

This combined approach aligns CalPERS' benefit design more closely with other large employer offerings. For large employers, the median office visit co-payment is $15 and many large employers, including the federal government, offer free preventive care. This combined approach may encourage contracting

agencies to continue coverage through CalPERS and motivate new public agencies to join.

Change to hospital inpatient co-payments: This change combines an inpatient co-payment of $100 per day ($300 annual maximum) with a standardized $15 ambulatory surgery co-payment (Currently: Kaiser charges $10, Blue Shield and WHA charge $0). This change encourages members to seek care in the most appropriate, cost-effective setting by creating a co-payment differential between inpatient hospital and ambulatory surgery. This change provides members with a financial incentive to choose ambulatory surgery over hospital inpatient care, when possible, while capping annual expenditures for inpatient hospital stays at $300. The cap will help mitigate the financial impact to members who may require frequent hospitalization.

The literature is mixed regarding the impact of hospital inpatient co-payment changes on member behavior. In Milliman's opinion, health carriers would typically not assume behavioral changes in pricing such a benefit change. The literature does indicate small incremental changes in other co-payments do not cause patients to forgo needed care resulting in decreased quality of life.

Change to pharmacy co-payments: HMO Basic plan pharmacy co-payments are currently $5 generics, $15 brand, and $45 non-formulary at retail and $10/25/75 for a 90 day supply through mail order. The proposed benefit design changes:

- co-payments for all brand pharmaceuticals to reflect the industry median, and the
- ratio between retail and mail order to 1:2 (the current retail to mail order generic ratio is 1:1.7).

The result is a pharmacy co-payment structure of $5/20/45 for retail and $10/40/90 for a 90 day supply through mail order. Milliman proposes maintaining Kaiser's two-tier structure, changing co-payments to $5/20.

This change maintains the financial incentive to the member to obtain maintenance pharmaceuticals through the mail and increases the financial incentive to use generics for retail and mail order. This change will provide members who use brand and non-formulary drugs further incentive to try generics.

As noted above, Milliman believes that small incremental changes in co-payments do not cause patients to forgo needed care resulting in decreased quality of life and increased premiums. The proposed pharmacy co-payment changes do not exceed a $15 increase (brand and non-formulary mail order only).

Change to emergency room co-payments: Milliman's proposal changes the emergency room co-payment from $50 to $75 (waived if admitted), while standardizing the urgent care co-payment at the proposed office visit co-payment of $15 (currently: $10 for Kaiser, $25 for Blue Shield and $20 for WHA). This option encourages members to seek care in the most appropriate and cost-effective setting by creating a differential between emergency room and urgent care co-payments of $60. This change provides members with a financial incentive to seek care at urgent care facilities, rather than emergency rooms, while continuing to mitigate the financial impact to members who are admitted to the hospital.

By setting urgent care co-payment at $15 for all plans, the proposal encourages plans to compete on premium, rather than benefit design. In addition, by making the urgent care co-payment consistent with the office visit co-payment, the proposal eliminates additional costs for all members who become ill outside regular doctor office hours.

Based on Milliman's literature review, changes in emergency room co-payments do not cause patients to forgo needed care resulting in decreased quality of life.

Change to Out-of-pocket maximums: Both Kaiser and WHA have $1,500/member and $3,000/family out-of-pocket maximums. Blue Shield, however, currently has no out-of-pocket maximum. This change proposes standardizing the out-of-pocket maximum across all plans. This would provide Blue Shield enrollees with the same level of coverage our other HMO enrollees experience. Milliman estimates that adding an out-of-pocket maximum to the Blue Shield HMO basic plan will have no impact on premium.

Proposed PPO Basic Benefit Design

Milliman conducted an extensive review of CalPERS PPO benefit design. With few exceptions, Milliman found the PERS Choice basic plan benefit design to be consistent with the industry standard. Deviating from the industry standard may decrease the overall value of PERSChoice, jeopardizing our risk pool and making PEMHCA employers less competitive when recruiting employees. As a result, Milliman does not recommend extensive changes to the current PERS Choice basic plan benefit design. For the same reasons cited in the Proposed HMO Basic Benefit Design section of this agenda item, however, it does recommend changing:

1. Pharmacy co-payments from $5 for generic, $15 for brand, and $45 for non-formulary at retail and $10/25/75 at mail order, to $5/20/45 at retail and $10/40/90 for mail order
2. Emergency room co-payments from $50 to $75 (waived if admitted), while maintaining a $20 urgent care co-payment

Milliman proposes maintaining the benefit design differences for PERSCare and PERS Choice to ensure members have more than one PPO option.

VII. RECOMMENDATION:

This item is information only.

VIII. STRATEGIC PLAN:

This agenda item supports the Health Benefits Branch Three-Year Business Plan Goal to "develop and administer quality, sustainable health benefit programs that are responsive to and valued by enrollees and employers."

IX. RESULTS/COSTS:

The “Analysis” section of this agenda item provides premium impact information.

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